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ABSTRACT

Intake procedures is the common subject of four papers presented in this booklet. James P. Pappas discusses trends, a decision theory model, information and issues in his article "Intake Procedures in Counseling Centers--Trends and Theory." In the second article "The Utilization of Standardized Tests in Intake Procedures or 'Where's the Post Office'" by Joseph L. Daly, the use of standardized tests as a part of intake procedure is discussed. "The Utilization of Non Test and Self Report Data in Intake Counseling Procedures" by Robert F. Stahmann is concerned with gathering nontest data before and during the interview and implications for practice and research. Ralph Packard in his article "Initial Interviewing Procedures and Staff Roles in An Intake System in A University Counseling Center," discusses the intake procedure developed at the University of Utah, with common questions discussed and conclusions regarding the success of the procedures. (KJ)

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2120 Annex Building, Salt Lake City, Utah 84112

DISCUSSANTS:

John O. Crites, Ph.D., Director
University Counseling Service, The University of Iowa
Iowa City, Iowa 52240

James D. Linden, Ph.D., Associate Professor
Department of Psychology, Purdue University
Lafayette, Indiana 47907

RECORDER:

Robert E. Finley, Ph.D., Supervising Counseling Psychologist
University Counseling Center, 2120 Annex, University of Utah
Salt Lake City, Utah 84112

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Intake Procedures in a College Counseling Center

In a recent article, Sinnett and Daskin (1967) described a typical client's initial contact with a college counseling center. Characteristically, the client appears or telephones for an appointment. Arrangements for counseling are made by a receptionist independent of professional counsel and often without an explicit rationale for the assignment. These researchers suggest that utilization of intake procedures is unusual for college counseling centers. It was felt that centers have been resistant to intake procedures because the low number of interviews per client did not really necessitate it, and the university counselor's distance from the other mental health professionals who use such procedures made him insensitive to their value (Sinnett & Daskin, 1967).

Their description of the typical assignment procedure was extremely valid for the situation at our counseling center at the University of Utah prior to this academic term. During the last few years, our staff has experienced increasing service and professional demands which eventuated in our adoption of a formalized intake procedure for our center. We saw our movement in this direction as a local manifestation of general national trends. We thought it important to share what we perceived these trends to be, so that others may hopefully recognize their emergence and respond to them on other campuses.

Also, in hope of assisting others considering intake procedures, I will develop a limited conceptual model of such procedures for heuristic value, the significant elements within these procedures, and describe the issues that these procedures raised for us.

Trends

We identified seven trends that we thought led us towards the use of intake procedures.

(1) The first, and probably most significant trend, was the increasing number of students enrolling in our university. This is certainly typical of the national scene (Bureau of Census, 1968). Larger student bodies provide concomitantly larger caseloads, which force counseling centers into situations where they must develop long waiting lists (Sinnett & Daskin, 1967). It has been impossible in the college counseling setting, as in the other mental health and educational settings, to provide an increase in trained professional staff at the same rate as the increasing client needs (Strother, 1957). Perhaps Nygreen's (1962) prediction is now being realized: "Counseling centers will be unable to maintain an open policy of service to any and all students who wish to avail themselves of it (p. 34)."

(2) A second significant trend we observed was also predicted by Nygreen (1962), when he suggested that there would be an increasing alienation and distance between the teaching faculty and students. This distance, which has become increasingly visible on ours and other campuses, has destroyed the informal counseling and advising contacts that were so useful to students in the past. Large classroom enrollments, often in the hundreds, and rewards for the research function, has made the instructor an inaccessible figure. As Caplow and McGee (1958) suggest, the student is now forced to seek his help and advice from the counseling center, or some other part of the "non-academic civil service" of the university.

(3) A third trend we experienced was the emergence of our center into a service rather than a training agency. Our primary function, as a result of administrative funding, is labelled as service, and we are a separate entity from an academic department. While this was partially true in the past, the counseling center developed as a training auxiliary of the educational psychology department. Despite this, however, we still felt it important to

retain a training and supervisory function as a part of our operation. Thus, we became trapped in a type of dissociative reaction, where we presented ourselves to the campus community as a professional service agency where a client may legitimately expect a non-apprentice staff, and yet we retained a number of counselors-in-training as part of our service personnel. Because of this, intake procedures seemed essential if we were to provide the appropriate professional service to the students "suffering" severe emotional difficulties that required non-apprentice staff and at the same time provide appropriate cases for our trainees.

(4) Another professional trend that influenced our adoption of intake procedures was our movement towards becoming what Pussell (1965) described as a "unified" counseling center. According to him, such a unified center would include, as part of its staff, social work counselors and psychiatric consultants, along with the traditional vocational counselors, clinical and counseling psychologists. Our acceptance of this model, with the integration of the various professionals, appears to have added impetus towards intake procedures. Associations with these professional groups, often with the support of the clinical psychologists, have helped to develop a feeling for a "diagnosis" and an awareness of the utility of conceptualizing a case prior to the beginning of treatment. In addition, the presence of this different type of professional has sensitized our staff to selecting clients for them that can receive special benefits from their unique skills.

(5) A fifth professional trend was related to this latter point. This is the trend towards the increasing diversity of available "treatment" approaches or "helping" techniques. The situation is no longer simply one of assigning a client to a counselor who will use some variant of one-to-one insight-oriented or test-oriented counseling, with semantics being the key

difference in approaches. Three significant factors have emerged almost simultaneously and their emergence demanded some formal assignment procedure. The first of these was the "explosion" of group activities available to clients. Our center, which does not seem to be unique in this area, has developed offerings in counseling groups, T-groups, sensory awareness groups and study skills groups (Bradford, Gibb & Benne, 1964; Rickabaugh, 1969). There appears to be no limit to the diversity of group techniques that are appearing nationally and being replicated in counseling centers. A second factor in this increase of treatment options seems to be related to the increasing acceptance and success of the behavior modification procedures. Desensitization to test anxiety, assertive training, reinforcement of study scheduling (Wolpe,& Lazarus, 1966; Fox, 1962) are merely a few of the techniques that can be made available to our prospective clients. Another element that has increased our services, with the resultant need for specific assignments, has been the adoption of the developmental model by our staff members. Ours and other counseling centers now feel compelled to offer "growth" experiences and services to the "normal" client, (e.g., leadership training; "strength groups") in addition to dealing with the problems of atypical students. This developmental philosophy has led to the solicitation of participation from student populations that typically would not be involved with a counseling center. These populations, in addition to increasing the already large caseloads, need care in assignment to an initial contact, so that they do not perceive themselves as being treated as "sick."

(6) Another significant professional trend for us has been the increasing availability of a diversity of specialized student personnel services. For example, presence of a university hospital, with a psychiatric clinic, offers a referral agency for clients needing hospitalization as an optional treatment.

(e.g., potential suicides). The development and formalization of effective student personnel services such as a placement service, financial aids office, a marriage and family counseling center, a speech and hearing clinic, and a military relations office have all contributed to the increased availability of possible "treatment" assignments outside of the counseling center.

(7) One final trend that seemed to be contributing to the establishment of an intake procedure, was the increasing specialization of counselor roles within the center. Many counselors no longer fit a generalist model. Rather they may perform primarily as a specialist in areas like group counseling, minority-group advising or study skills development, with the traditional roles of vocational counseling or psychotherapy as only a small part of their practice. Enhancing the growth of such specific-title counselors is the increasing complexity of the university and the maturation of the applied psychology professions. The large amount of knowledge the present-day counselor must have in order to simply fulfill his information-giving function or to make referrals to appropriate agencies has also forced this specificity of counselor roles. As multi-universities continue to develop, the complexity of this information, both about types of curriculum and methods of succeeding in the college setting, will force the assignment of specific problems to specialist counselors. Unfortunately, the era of a single counselor having experiential information relating to his institution is passing.

Decision Theory Model

The establishment of intake procedures has meant that a new set of roles were established for our counselor-intakers and our clients that were not present under the old assignment system. The counselor previously assumed that his first contact with the client was the first of a series of contacts that hoped to effect some "help" change for the client. The client also

assumed that his "problems" would be dealt with at that time. Under the intake format, the counselor-intaker and the client may or may not attempt to deal with the "problem." They will be involved more often in choosing among the variety of alternate courses of action. One of these alternatives might be dealing directly with the presenting problem, while others would be the choice of treatment and choice of counselor. This situation then, choosing among various courses of action, constitutes a decision problem. If we state it in these terms, we suggest that a decision theory model (Cronbach & Gleser, 1965; Edwards, 1954) would have significant promise for providing a frame of reference to conceptualize the intake process that has been discussed. Given the time limitation of our situation, such a model, of course, cannot be fully developed. However, a tentative adaption of the models suggested by Cronbach and Gleser (1965), Gelatt (1962) and Wickert (1962) may be useful.

Before such a model can be presented, some basic definitions are necessary. Let us begin with the word treatment. Treatment in the intake context will have a broad meaning covering all possible alternative choices the client-counselor dyad might make related to services offered by the counseling center, and other campus or community agencies. Another set of important decision theory concepts are related to the aspect of selection and placement. The term selection categorizes certain types of institutional decisions about individuals, where one of the alternatives available is rejection of the individual. It is possible, when counseling centers have such high case loads that they are not able to see all clients who present themselves and some quota must be established, that an appropriate decision procedure might relate to selection. In our counseling center, it was assumed that the agency-client decision to be made is related to placement. Placement suggests that the individual must be assigned to one of the treatments available and that rejection of the

individual is not an alternative.

Strategy is another term frequently encountered in discussions on decision theory. Strategy has been defined as a rule for arriving at a decision (Wickert, 1962). This seems to be a useful characteristic of any decision model which is appropriate for a counseling center intake procedure. Very often, there are a variety of implicit decisions made by counseling centers relating to clients (e.g., we will seek medical consultation on suicide cases). An intake procedure that seeks to specify its treatment then, is forced at some point to overtly and explicitly establish its decision rules for the variety of clients and treatments it has available. We found, that without the pressure of an intake procedure, these types of implicit assumptions or operating rules would never have been made explicit. This establishment of rules or strategies is particularly important in developing a philosophical statement of the goals of a counseling center. A secondary gain, then, of establishing an intake procedure, is that the philosophical assumptions of the counseling center are stated overtly. This suggests, as Cronbach and Gleser (1965) point out, that when the strategies are made explicit, then the decision maker is often surprised to find that additional possibilities may be available for treatment of which he was not previously aware.

In discussing decision-making strategies, the issue always arises whether the procedure will be sequential or non-sequential. In a non-sequential strategy, the decision is made for one of two alternatives. The choice at that point then becomes irrevocable and the decision maker must complete the treatment established. It seems more appropriate, in discussing counseling center intake procedures, to assume that the strategies will be non-sequential -- that is that the client will always have the option in the strategy sequence of choosing an alternative that was not previously chosen.

Given the information that is generated from the intake procedure, and given a series of sequential strategies, the client-counselor dyad are led to making a decision. The decision, or choice of alternate treatments, may be terminal or investigatory. A terminal decision is one that ends the decision making process by assigning the individual to a given treatment. An investigatory decision calls for some additional generation of information, or some treatment procedure that seeks to enhance later decisions. The investigatory decision then leads to a further decision, and a cycle of additional investigatory decisions, information gathering and decision-making that continues until a terminal decision is made (Cronbach & Gleser, 1965). A decision is actually terminal only from the viewpoint of the particular decision maker. Once the terminal decision as to treatment assignment has been made, the individual's performance in that treatment is the <u>outcome</u> of the decision making process. An evaluative statement of this outcome (e.g., has a "cure" been effected) is the <u>payoff</u> for the decision making process. A value system must then be developed by the decision maker(s), weighing the desirability associated with the outcomes. Generally in our procedures, we followed Tyler's (1961) suggestion that the process involved established a "good" decision if the decider is willing to accept the responsibility of the consequences. The counselor-intaker's role in this process appears to be one of assisting the student through the investigatory cycle (Gelatt, 1962). The problem is to find the procedure which, in the time available, offers the greatest yield in important relevant and interpretable information (Gelatt, 1962). As Cronbach and Gleser (1967) point out, it is necessary to distill from a limited quantity of information, the most intelligent possible decision. Thus, for the decision process of the intake to be effective, there are some basic categories related to the information that must be considered. The information of concern is: (a) alternate actions, (b) possible outcomes, (c) relationships

between these actions and outcomes, and (d) relative preferences for the possible outcomes (Gelatt & Clarke, 1967).

In the intake decision making process we have a situation as represented in Figure 1. In this figure, there seems to be initially parallel and later joint decision making processes that have been defined. These processes summarize, in part, the situation of the intake interview. On one side, the individual client begins a decision making sequence. There is some motivating state present, either in internal need or institutional pressure (e.g., probationary students), which leads the client towards an investigatory decision of seeking assistance at a counseling center. On the other hand, the counselor-intaker is established in the decision making process by the role demands of his position. In the intake contact, the two generate shared information as is indicated. This includes biographical data, test data, descriptions of problems and programs, and interview interactions. This shared information represents the key elements of the intake procedure. On the basis of these elements, the counselor-counselee dyad then seeks to establish strategies for election of a treatment. If the client's primary need for seeking assistance is related to information-giving, then the interactive process may establish a terminal decision to provide the information and an outcome. If, however, the client needs are related to some additional treatment situation, then a terminal decision is made for the dyad to place the client in some treatment, a...n, and an agency-counselor-client "contract" is established. Such a "contract" guarantees a client the treatment with a qualified counselor at a certain time. The client guarantees to appear and decide if he wishes to participate, having examined the treatment situation,

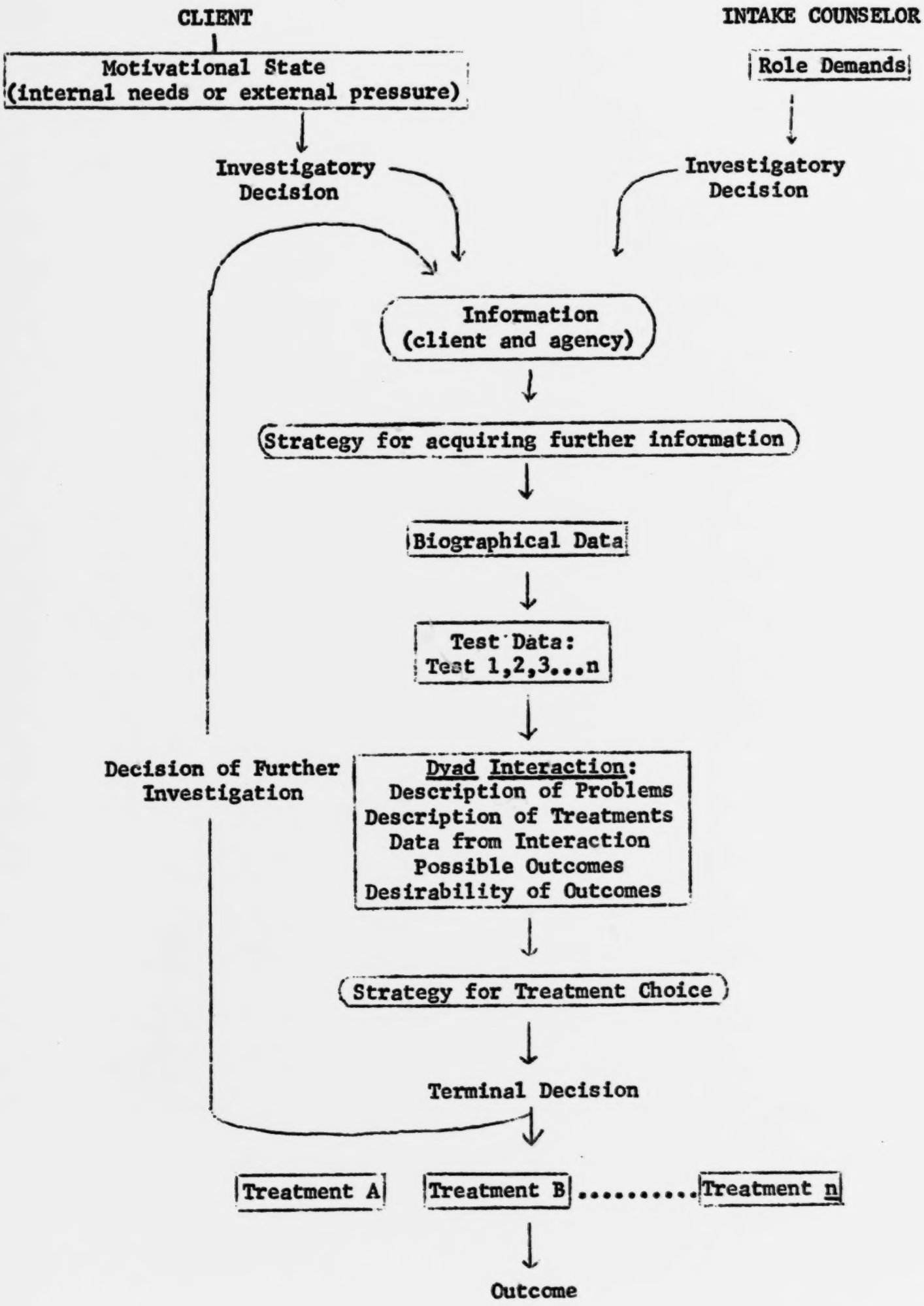

Figure 1. Schematic representation of a decision-making intake procedure.

Information and Issues

Having functioned with an intake procedure during this year, we have been confronted with the necessity of exploring in depth the nature of each of the elements described above (i.e., biographical data, testing procedures and the counselor-client intake inter-action). This exploration, at our center and the counseling center at the University of Iowa, has led to the papers that will be presented by the subsequent speakers.

In addition, the intake procedure has raised a variety of questions that we had not been confronted with before its beginning. These include the following:

---Who will perform the intake role? Will it be the professional staff, or will it be the counselors-in-training?

---Does the intake role require special training?

---Will the counselor-client dyad make the final treatment assignment, or will some type of staffing be required for the terminal decision?

---Will the counseling relationship be limited in any way?

---Should clients be required to complete autobiographical forms and test batteries prior to the intake contact?

---How much involvement should the client have in the choice of treatment placement?

---Should clients be advised of differential counselor experience and training before the initial treatment contact, or should that be described by the treatment counselor?

---Should clients be assigned to more than one treatment?

While the subsequent speakers and discussions will address themselves, in part, to these issues, we hope that those of you in the audience will also make explicit your strategies in this area.

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THE UTILIZATION OF STANDARDIZED TESTS IN INTAKE PROCEDURES
OR
"WHERE'S THE POST OFFICE"

Intake procedures at a university counseling center should be designed to provide more meaningful counseling through better utilization of the center's staff and programs. The primary purpose of intake is to facilitate counseling. To discuss the role of standardized tests as a part of intake then, suggests examining the guidelines pertaining to the use of tests in counseling and seeing what implications these might have for intake.

At the turn of the century, Parsons [9] stated that the wise choice of a vocation involved three broad factors: (1) a clear understanding of oneself, (2) knowledge of requirements and conditions of success, and (3) true reasoning on the relationship of these two sets of facts. While Parson's approach may be somewhat simplified much of what we presently do as counselors can still be classified under the three headings he suggested: providing the client with (1) information about himself (2) information about the choices and alternatives available to him, and most importantly (3) a setting where he can carefully examine the meaning of such information as it relates to him and his future.

Tests have become an important part of counseling since they are one of the main sources of information for both the counselor and the counselee.

Just a few years back Goldman [7] suggested that there had been a revival of educational and vocational counseling and of cognitively oriented guidance in general as contrasted to what he described as an earlier emphasis on pathology and emotions. In other words, a movement of counseling back toward its earlier

role, as typified by Parsons, of helping people to make plans and decisions about very concrete aspects of their lives.

More recently, in describing what he sees as an "excellent development," Barclay (2) has indicated a tendency within counseling, to shift from the use of tests to supplement clinical judgment about an individual to the use of tests and test information as a basis for client-counselor decision-making.

Meyering illustrates this trend when he states that "counseling consists of establishing a relationship in which the counselee can explore his own personality and the environmental forces which are acting upon him. Out of this experience, he becomes aware of the possibilities open to him and free to make decisions affecting his future. Tests are one source of information which the counselee uses in his search for self-understanding." (8:38)

The use of test data, however, is determined by a large extent by the theoretical views of the counselor. For those with a clinical orientation the provision of information for the counselor is extremely important. For the counselor more inclined toward the client-centered point of view, tests are useful in counseling only to the extent that they can provide meaningful information to the counselee. And for some, tests have no use at all.

For the past year or so, I have been teaching a class in measurement and evaluation for prospective teachers. Some of the points I have been trying to make with them relative to the proper selection of standardized tests seem relevant here. I point out to them that standardized tests play such a vital role in the school pro-

gram that they must be selected with the utmost of care. Tests which are selected hastily or casually seldom provide adequate or appropriate information on which to base educational decisions. Moreover, such tests can actually have a negative influence because they are usually not in complete harmony with the overall objectives of the program. Such cautions seem even more necessary in counseling where the emphasis is, or should be, on the uniqueness of each client and the individualized use of the test results.

The story is told of a protestant minister who had just arrived in one of our large cities for a series of revival meetings. He had a letter he wanted to mail and, not knowing where the post office was, he stopped a youngster on the street to ask directions. After getting the proper instructions the minister thanked the young man and, being filled with the spirit of his calling, told him that if he would come to a certain location that night he would show him the way to heaven. ----- To which, it is said, the youngster simply replied "heck, mister, you don't even know where the post office is." Rephrasing just a little, it would seem to be of little value to try to guide all our clients to heaven with a fine battery of standardized tests, when all they may want is to know where the post office is. The information a client needs is relevant only in terms of what he wants to know.

As a young graduate student, I remember sitting in my first class in the area of educational and psychological measurement and hearing Dr. Robert Travers say that counseling and counselors were going to have a hard time accomplishing much until we could state what our goals were -- and state them clearly in terms of specific client behaviors. Since then, of course, at least according to John

Krumboltz and others, we have undergone, a "revolution in counseling" where the goal has been to do just what Travers suggested.

In any event, before tests can be used intelligently in counseling or in teaching, it is necessary to define specifically the type of information being sought through testing. Selection must be preceded by careful analysis of the intended uses of the results and of the type of test data most appropriate for each use.

I indicate to my students that it is necessary to identify those objectives of teaching (in this case counseling is our concern) which can best be served by means of standardized tests. Then the need for tests can be appraised in accordance with other available information -- test and non-test. This helps also to clarify the nature of the standardized tests that might be selected.

In counseling tests should provide information relative to a particular client's needs and the information obtained should add something to existing information or information available from other sources.

We are unanimous in explaining that test information to be of any use at all must be valid - and valid for the purpose in question. But we sometimes forget, as Downie [5] has suggested, that one of the important problems in testing is how to motivate the examinee to the point where he will turn in a paper that is a good measure of himself. Clients will not always do their best on tests and many of our tests are based on the assumption of the old college try for proper interpretation. On interest and personality tests there is also the possibility that a client may be inclined to lie a little -- to himself as well as to the counselor. An additional concern is that even if properly attempted there is no guarantee that the results will be accepted by the client.

The proper use of tests within the total counseling process necessitates more time than is available during an intake interview. While proper assignment of clients in light of available staff and programs may be a legitimate aim of intake, proper utilization of tests seems difficult if not impossible.

Another reason why I would suggest that standardized tests should have little use as a part of intake relates to the increasing criticism of tests and testing by our society. Tests have become a very volatile toole for the counselor or the clinician. There is a good possibility that our methods of introducing and interpreting tests have had a good deal to do with the problems we face in this area. In counseling where we indicate that rapport is so critical, where much of the process rests on the assumption that the client will be willing to make use of information about himself obtained from tests, the opinions of our clients must be of special concern to us. It is essential that we do all we can to bridge any gap that might exist between our tests and our clients.

In addition, there is our concern with the ethical problems raised by the criticisms of tests and testing. In discussing the protection of privacy as it relates to testing, Anastasi (1) suggests there are two key concepts that must be kept in mind: relevance and informed consent. She indicates that any information that the client may be asked to reveal must be relevant to the stated purposes of the testing, and that the client as aminimum, should be informed about the purposes of testing, the kinds of data sought, and the use that will be made of the scores.

Ebel (6) has indicated that most of the decisions affecting the welfare and future of a person are made in the midst of many uncertainties. He suggests that

one of the cornerstones of a free society is the belief that in most cases it is better for the person most concerned to make the decision, and to take the responsibility for its consequences. Tests from this point of view, should be used as little as possible to impose decisions and courses of action upon others. They should be used instead, to provide a sounder basis of choice in individual decision making.

Meyering (8:15) in a recent publication presented eight points to guide counselors in the ethical use of tests.

1. The counselor must have a general understanding of the behavior being measured and provide the counselee with the best available tools for developing self-understanding of his behavior.

2. The limitations of appraisal instruments must be communicated to the counselee so that he can meaningfully interpret his test scores.

3. The counselor should not use tests which are beyond his competence to administer or interpret.

4. Tests should not be used for purposes other than those for which they were developed.

5. No client in counseling should be required to take standardized tests against his will.

6. Tests which ask questions of a personal nature should be used only for counselee self-evaluation and not to satisfy the counselor's curiosity or to secure personal advantage.

7. The counselee should understand the purposes of all tests administered during the counseling process.

8. The counselor's primary responsibility to the counselee. Test data used in the counseling process is the property of the counselee to be used only as he wishes.

As Goldman (7) has indicated the process of test selection must be an integral part of counseling and some client participation seems desirable and certainly worth any difficulties it might create.

One additional point. As was mentioned earlier, the use of tests in counseling is still very dependent upon the theoretical framework of the counselor involved. There is not complete agreement within the profession as to the role which tests should play in counseling. The question of whether tests should be used at all is still being raised, and those who agree that tests do have a place in counseling do not agree completely on how they should be used. And, as Goldman (7) indicates, there is not, nor is there likely to be a best method for assigning and making use of tests.

Yet, one of the real strengths of any counseling center is to have a staff comprised of individuals with differing skills and viewpoints. And one of the advantages of an intake system is to utilize these differences to the maximum. Just such differences in persuasions argues for leaving testing until after the initial intake is completed. This will allow the given counselor to proceed in keeping with his own bent, as well as provide for the other steps that have been mentioned previously.

Intake procedures should maximize a counselor being able to do his own thing. If tests are not his bag, they should be forgotten. Those who choose to make testing an integral part of the counseling process should be able to do so,

and those of a more clinical nature should not be hampered from diagnosing and prognosing to their heart's content.

The primary function of intake as I have discussed it is to facilitate counseling. There are, however, two other possible functions that need to be mentioned: selection and research.

To the extent that the defined role of a given counseling center may restrict the type of client that should be served some screening may be necessary. However, the use of standardized tests still seems limited. The main problem would be finding a test appropriate to the task. Since the decision to be made is one of accept or reject, the implication is that the test scores will provide the basis for making a dichotomous judgment -- which is seldom true. There are also the many problems related to obtaining reliable, valid information that have already been mentioned. Cronbach and Gleser [4] have pointed out the difficulties that can develop when one attempts to make a decision about people using a number of indices. It seems that we cannot keep more than a few selected variables in mind at any one time anyway, and extensive information can often serve to confuse the issue. Sometimes, however, as Barclay [2] points out, a brief screening device can provide some useful information and in this limited fashion testing may have some use as a part of intake.

There is also the possibility that some research relative to a center and its services may suggest the gathering of information as a part of the initial intake interview. And since no one argues with the necessity for research, once an appropirate design has been devised, I will not quarrel with research related testing

as a part of intake; in spite of the impression I sometimes get, that many intake procedures are established primarily to facilitate research and not to facilitate counseling. It would seem important, however, for the intake interviewer to keep in mind the necessity of preparing the individual for any testing that is to be done and to explain carefully the purpose for his participation.

In summary, and using research as a spring board, it is precisely the need for a proper research design, if you will, that I see little use for standardized tests as a part of the intake procedure. Appropriate goals will not yet be established for the client in question and the amount and type of information relative to the specific problem under consideration will not have been determined. Remeber all of our clients may not want to go to heaven/

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Joseph L. Daly
Asst. Professor
Department of Education
Colorado State University

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UTILIZATION OF NON-TEST AND SELF-REPORT DATA IN INTAKE COUNSELING PROCEDURES[1]

Robert F. Stahmann

University of Iowa

What types of non-test data about clients are available to counselors prior to and during the intake or initial interview? Are client self-report data, as might be obtained in an intake interview, valid? Questions such as these confront counselors as they study intake interview procedures. This paper reviews the techniques and types of nontest data available to the counselor prior to and during the intake interview and reviews related research reported in the professional literature. Implications for practice and research are discussed.

There are two primary distinctions which can be made between the data collected prior to the intake interview and that collected during the interview which might help us to conceptualize the type of data that counselors are dealing with. First, data collected before the interview are historical or "old." That is, time has elapsed between the interview the information was collected and the time that that the counselor uses it. Second, these data are almost all written, typically by the client or another person who is in a position to rate the client. The fact that these data are written is important in that they are permanent and generally verifable

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as opposed to data which arise during the interview and might be forgotten, distorted, or completely missed by the counselor. The counselor can often study various non-test data prior to the intake interview and verify or expand upon them during the interview.

Figure 1 depicts the techniques for gathering self-report and non self-report data prior to and during the intake interview which are discussed in this paper.

Insert Figure 1 about here

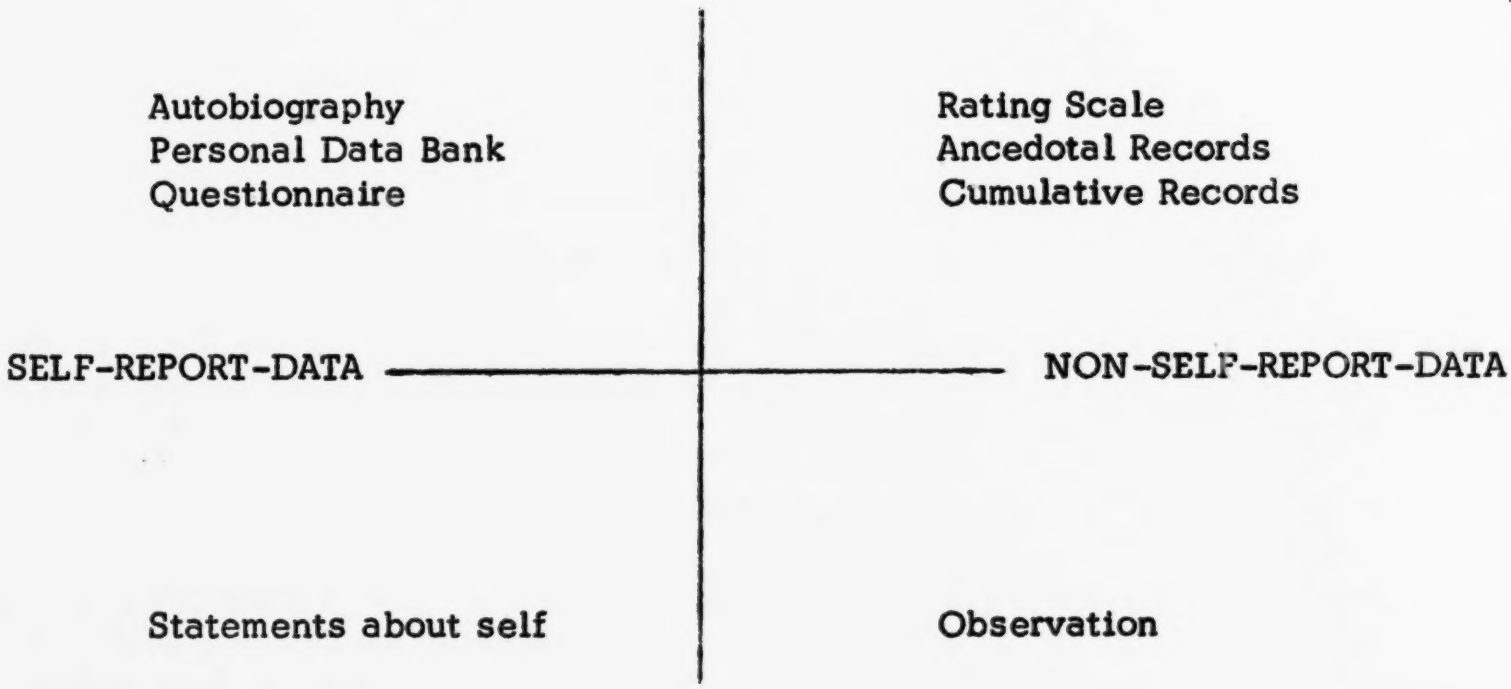
I. Gathering Non-Test Data Before the Interview

The general counseling literature refers to six basic techniques or sources for gathering non-test data about clients in an academic setting before the interview process begins. These techniques are: the personal data bank; autobiography; questionnaire; rating scale; ancedotal record; and cumulative records. The personal data blank, autobiography, and questionnaire have received much more emphasis in the literature than the other techniques.

Self-Report Data:

Autobiography. The autobiography has been described as "an individual's own written introspective report of his own life (Annis, 1967, p. 10)." Generally, two basic types of autobiographies are identified, the comprehensive or free response autobiography in which the person writes about a wide range of experiences over a relatively long period of his life, and the topical autobiography in which the person deals with a more specific topic, theme, or experience (Annis, 1967; Brammer & Shostrom, 1968).

BEFORE INTERVIEW



DURING INTERVIEW

Figure 1. Graphical representation of techniques for gathering self-report and non-self-report data prior to and during the intake interview.

The information which can be obtained through the autobiography is considered to be potentially useful to the counselor. For example, Froehlich and Hoyt (1959) point out that information about the client's personality characteristics and environmental background can be obtained from the autobiography. The autobiography written prior to the intake interview would certainly yield perceptions about the client's life experiences and present problems, and give the counselor, as Tyler (1961) suggests, an idea as to what might be the appropriate focus of the interview. This technique also may provide data which make other data that the counselor has more meaningful (Warters, 1964).

In addition to this rather clear-cut overt information, other inferences can be made about the client based upon such things as what is discussed or ommitted from the autobiography, vocabulary, level or depth of expression, and organization (Froehlich & Hoyt, 1959).

Personal Data Bank. The personal data blank (PDB) is composed of questions or phrases to be completed by the client. Typically these questions and phrases concern identifying data, home and family background, academic background, vocational and avocational interests, health, peer relationships, expectations from counseling and other items depending upon the setting in which the information is used.

Frank Parsons, the acknowledged father of vocational guidance, gave a detailed description of collecting personal data from the client (Parsons, 1909). His method is well worth reading because it is the forerunner of modern PDB techniques. However, Parsons confounds his personal data blank with so many

direct questions that we might more properly consider it to be a quesionnaire, the primary differences being direct questions versus more open statements which are characteristic of personal data blanks. See Tyler (1961), pages 297-300, Williamson (1950), pages 285-536, and Froehlich and Hoyt (1959), pages 324-326 for examples of currently used personal data blanks.

Some counselors feel that "the use and interpretation of the personal data blank prior to counseling not only saves the counselor a great deal of counseling time which would otherwise be spent in collecting much the same information, but also allows him to plan more intelligently for the interview and to be more receptive to cues he receives from the student during the interview. (Froehlich & Hoyt, 1959, p. 342)." The personal data blank administered just prior to the intake interview also gives the counselor current corss-sectional data about the client which may be used to update any cumulative or longitudinal information that he has concerning the clinet (viz: cumulative record, personnel record).

Questionnaire. In contrast to the personal data blank which is somewhat open-ended, the questionnaire requires that the client respond in writing to direct questions, for example, "What is your intended field of study?" As Super and Crites (1962) point out, the questionnaire is a frequently used device for gathering interview type data.

It appears that little if any distinction is made between the questionnaire and the personal data blank in much of the literature (Warters, 1964; Super and Crites, 1962; Froehlich and Hoyt, 1959; Williamson, 1950). This writer believes that such a distinction between the two techniques would be helpful, particularly when con-

sidering their use in counseling. Following Walsh (1967, p. 19), in the questionnaire method of eliciting data the client is asked "to respond in writing to direct questions, for example, 'What was your high school gradepoint average?' 'How many semesters have you been on academic probation at SUI?'" In contrast, using the personal data blank technique the client is asked "to respond in writing to statements rather than to direct questions, for example, 'High School GPA_____:' 'Numbers of semesters on academic probation at SUI _____. (Walsh, 1967, p. 19).'" Clearly the two techniques are different.

Non-Self-Report Data:

Rating Scale. The rating scale is an attempt to quantify observations of behavior in an objective manner. The observer reports a general estimate (based on observation) of the individual's relative strengths and weaknesses with respect to the characteristics indicated on the scale (Warters, 1964).

Typically the reliability and validity of rating scales are not high. The reasons for this are widely discussed, among them being the fact that often the criteria used for rating scales are subjective judgments and usually made by untrained, often biased raters. Rating scales typically are ambiguous and can mean different things to different raters. The format may be confusing or appear awkward to many raters thus confounding the ratings. However, Warters (1964) believes that many of these difficulties can be overcome by training the raters and that the rating scale can become a much more reliable and valid source of information. Both she and Super and Crites (1962) point out that because of its high face validity the rating scale is widely used. Warters indicates that valuable data often are obtained from rating

scales, while Super and Crites believe that little valuable information is provided by this technique for counseling.

Anecdotal Records. The anecdotal record consists of descriptions of behavior as observed in specific situations. Anecdotal records are similar to rating scales in that they are recordings of observed behavior, but differ in that they more completely describe the observed behavior and often include either interpretations of the observed incident and/or recommendations arising from the observation. However, the users of anecdotal records are cautioned against confounding objective descriptions of behavior with observer interpretations of the incident or with recommendations (Froehlich & Hoyt, 1959; Warters, 1964). When interpretations or recommendations are made they should be identified as such as distinctly set off from the description of the behavior.

Anecdotal records are typically made up of a number of behavioral descriptions collected over a period of time, often throughout a student's school career. These longitudinal reports, when collected in the student's file, can become very useful in constructing a dynamic and characteristic picture of the student and help the counselor in making judgments concerning his probable behavior in other situations (Super & Crites, 1962).

Cumulative Records. Cumulative records are comprehensive records that show a student's progress and development in a number of areas over a period of time. Ideally, the cumulative record would span the time the student entered school until the time of graduation or withdrawal (Warters, 1964).

The information contained in the cumulative record can often be of significant value to counselors, particularly as a redily available source which can be tapped prior to the intake interview. However, a primary problem with the cumulative record is keeping it up to date.

Froehlich and Hoyt (1959) point out that information in the cumulative record can be supplemented and expanded upon by the use of the personal data blank administered prior to the first counseling session. I would add that perhaps the personal data blank would be come part of the client's confidential counseling record and stay in the counseling office, whereas the cumulative record may be returned to a central administrative file.

II. Gathering Non-Test Data During the Interview

Once the counselor and client are seated in the counselor's office and the interview has begun, the data gathering techniques become somewhat different than those in the foregoing discussion. The assumption underlying this discussion is that once the intake interview has begun the client is the sole source of information about himself. The counselor is himself the means for gathering information about the client. In the intake interview such an information obtaining task on the part of the counselor may be crucial because the decision as to whether to accept, refer, or reject the prospective client is often made on the basis of this interview. What then are the techniques available to the counselor?

Statements about Self. An obvious source of information about the client would be statements which he made about himself. Such statements could be volunteered

by the client or obtained in an unstructured interview (Arbuckle, 1965; Brammer & Shostrom, 1968; Tyler, 1961; Froehlich & Hoyt, 1959; Warters, 1964). On the other hand, the counselor might choose to follow an interview schedule, that is, follow an outline of specific questions or topics on which he wants to obtain answers from the client (Gruen, 1968; Kerlinger, 1965; Super & Crites, 1962; Parsons, 1909; Warters, 1964). Regardless of the technique used, the counselor here is obtaining verbal self-report information. The counselor's primary task is to listen and attempt to understand what the client is communicating verbally.

Observations. A second technique by which the counselor can gain information during the intake interview is through observation of the client's behavior. Here the counselor is getting cues and perhaps responding to overt behaviors such as posture, gestures, bodily reactions, glances, voice tone, etc. The counselor's primary task here is to observe the client and attempt to understand what he is communicating non-verbally.

III. Related Research

The studies reported in the professional literature dealing with non-test and self-report data in college counseling are few in number and those dealing with the utilization of such data in intake interview procedures are virtually non-existent. The following studies appear to be relevant to the topics of self-report data and counseling in the college setting.

Annins (1967) provided a comprehensive review of the uses and values of the autobiography in professional psychology. He pointed out that the autobiography

has received much acclaim as to its use and values, but "this has been primarily at the testimonial level (Annis, 1967, p. 14)." Annis concluded that "it seems unfortunate that professional and scientific psychology have not employed and studied a communication instrument with the potential of the autobiography more extensively (Annis, 1967, p. 15)."

Walsh (1967) reported a study in which he compared the validity of three methods of eliciting self-report data for a sample of male university students. His review of the literature revealed the following: In some 27 studies concerned with the validity of interview data, 13 gave impressions of high validity, 9 of low validity, and 5 studies yielded ambiguous results. He reviewed 7 studies which looked at the validity of questionnaire data and found that 3 reported high validity and 4 reported low validity. In reviewing studies concerned with the validity of personal data blank information Walsh found three which reported high validity and two which reported that the validity of personal data blank information was suspect. Such findings certainly do not leave the counselor with a clear cut impression of the validity of self-report data.

Walsh (1967) designed his study to investigate the accuracy of the interview, the questionnaire, and the personal data blank for collecting data which were verifiable from an examination of university student records. He found that no one method elicited more accurate self-reports than another and that a financial incentive to stimulate distortion of self-report was not associated with the accuracy of the self-report. In general, the students (men) gave quite accurate responses to the informational type items in the study.

A year later Walsh (1968) completed another study, this time looking at the accuracy of the questionnaire and interview for collecting verifiable biographical data from male and female university students under varied conditions. He reported neither the questionnaire nor the interview method elicited more accurate self-reports than the other. He also found that an experimental social incentive to distort had no statistically significant effect on the accuracy of self-reports. These results held up for both sexes. Similarly to his earlier study Walsh found that the self-report information was generally accurate, showing evidence of high validity.

Holland and Lutz (1968) studied the predictive validity of a student's choice of vocation and compared the predictive validity of his self-expression with his scores on the Vocational Preference Inventory (VPI). The time intervals between choices were 8 and 12 months. The investigators found that the predicitve efficiency of student self-expressions of vocational choice were about twice that of the VPI, some 68% to 86% of the self-expressions being accurate. Holland and Lutz concluded that "researchers and counselors should make greater use of a person's expressed vocational choices and that interest inventories should be used with more discrimination (Holland & Lutz, 1968, p. 433)."

Stahmann (1969) compared the predictive validity of freshman entrance data--Occupational Interest Inventory scores (OII), achievement test scores, and responses to two questions on a university admissions questionnaire--for predicting major field of study at university graduation. For women, self-predictions, that is information from the freshman admissions questionnaire, were the most efficient predictor of major field at graduation. Seventy percent of the women had correctly

indicated their field of study at graduation when they completed their admissions questionnaire as freshmen. He found that, for the men, self-predictions and those based on the interest inventory (OII) were approximately equal. Here the correct predictions were about 55%.

The American College Testing Program collects two typse of self-report data as part of the ACT battery. The first of these data are the students' self-reports of their last high school grades in English, math, social studies, and natural sciences. ACT has reported (1965) that these grades are reported with a high degree of accuracy--70-84% of the student reports agree exactly with school records.

The second of the self-report data used by ACT is the descriptive information contained in the Student Profile Section of the battery. ACT has pointed out that these data "are valid in the sense that the student's response is the best single criterion; it is inconceivable that another person (a parent, teacher, or friend) or a special assessment device could provide more accurate information about a student's aspirations and expectations (ACT, 1965, p. 22)."

IV. Implications for Practice and Research

Implications for Practice: Based upon the foregoing discussion, a number of implications about the use of non-test and self-report data in intake counseling procedures can be drawn.

1. There are techniques, shown in Figure 1 and discussed in the paper, available to the counselor which can be used to elicit information from the client

prior to and during the intake interview. Basically these techniques are client self-reports and observations made by the counselor or another person. The counselor should be familiar with these techniques and use them whenever appropriate.

2. It would seem that on most college and university campuses there is a great deal of non-test information about students that could be obtained for use by the counselor prior to the intake (initial) counseling interview. Specifically, admissions questionnaire data might be available from the admissions office; biographical or other background information from the financial aids office; health information from the student health service; and academic information from the registrar's office.

3. Another implication for the practicing counselor would be that he should be aware of the limits of self-report and non-test data. These data are very easily distorted, both consciously and unconsciously. However, these data can also be absolutely accurate and valuable to counseling. The appropriate practice for the counselor would be to be aware of these limitations of self-report and non-test data and work within them by checking validity whenever possible.

4. The counselor must be aware of the fact that the evidence regarding the validity of self-report and non-test data is not clear clear cut. He cannot flatly reject the validity of such data, for some data such as self-reports of grade-point (American College Testing Program, 1965; Walsh, 1967), intended choice of vocation (Holland & Lutz, 1968), and self-predictions of major field of study (Stahmann, 1969) have been shown to be valid. However, the counselor cannot naively believe that all self-report data are valid. This has not been demonstrated.

Implications for research: There are many questions regarding the utilization of non-test and self-report data in intake counseling procedures which remain unanswered. The following are suggestive of the research that must be done.

1. Most basically we must study the question regarding what kinds of questions and what information can be accurately obtained by self-report and non-test techniques. Thus far studies have suggested that self-reports of college students regarding their grade point average (American College Testing Program, 1965; Walsh, 1967), intended choice of vocation (Holland & Lutz, 1968), and intended field of study (Stahmann, 1969) are accurate, but little else has been studied with college student populations.

2. The question as to whether one technique for obtaining self-report information from the client is more accurate than another remains unanswered. Studies suggest that there is little difference among the accuracy of the interview, questionnaire, and personal data blank (Walsh, 1967, 1968). However, these studies are only a beginning in an area of complex interacting variables.

3. In looking at each technique of eliciting self-report data, counselors need to study the format of the technique. For example, one study (Stahmann, 1969) reported that seemingly similar questions on a university admissions questionnaire yielded different answers as to intended field of study which resulted in differing predictive validity. Why? How do counselors ask questions or elicit information from clients so as to maximize accuracy of responses?

4. On-going study of the format of written self-report devices is necessary. Is the questionnaire or personal data blank ambiguous, difficult to understand, redundant or threatening to the client?

5. Most of the self-report and non-test data that counselors use are verifiable and should be studied. Granted, the method most desirable is often a longitudinal study which is difficult, time consuming and expensive, however it must be done to answer important questions which relate directly to the counselor's effectiveness in the intake interview.

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INITIAL INTERVIEWING PROCEDURES AND STAFF ROLES IN AN INTAKE SYSTEM IN A UNIVERSITY COUNSELING CENTER

Ted Packard
APGA Convention, 1969

The Importantce of the Initial Interview

Many a mother has felt compelled to inform a son or duaghter of the importance of an initial contact by saying something like: "Rember John (or Mary), first impressions are the most important." Many a counselor has had the intuitive feeling, unscientific as that may sound, that the initial contact with a client is most crucial in determining the course of the relationship and, indeed, if there is to be a further relationship. Stone and Shertzer, in an introduction to a recent book by Perez (1968), stated that:

> The first counseling session is, as Dr. Perez so appropriately stresses, of utmost importance. The influence of initial impressions, the impact of first happenings on later sessions, and, indeed, the ultimate success or failure of a series of counseling contacts may be determined during the first crucial meeting (pg. vii).

Over the past two years our concern with the initial contact between client and counselor has led us to alter the conditions under which this introductory experience occurs in the Counseling Center at the University of Utah. Prior to the current academic year there was much similarity between our situation and the one described by Sinnett and Danskin (1967) and previously mentioned by Jim Pappas. In brief, a client appears or telephones for an appointment and is given one by the secretary or receptionist. If waiting lists are the order of the day then a routine assignment to such is made. Nowhere in the process is provision made

for professional judgment as to level of staff needed, or appropriate Counseling Center service to be provided. Furthermore, immediate contact with a counselor is obviously not a part of this traditional procedure.

Although we have prided ourselves on employing receptionists both pleasant to converse with and pleasing to behold, it seemed unrealistic to expect that their decisions as to assignment of clients might be based on factors other than expediency and availability of staff. Our feeling was that professional staff could more appropriately make such decisions and might provide a more meaningful and impactful "first impression."

Specifically, the following factors sparked our desire to change from the old system to a new and more formalized intake procedure:

1. There were a variety of services available in our Counseling Center (i.e., individual counseling, group experiences, and an efficient study program) which a new client might select.
2. There were a variety of levels of experience, and presumed competency, represented in counselors available to see clients (i.e., from Ph.D. counseling and clinical psychologists to graduate students in their initial practicum experience).
3. We desired to design a system that would make minimal the elapsed time between client request for service and contact with counselor.

The Intake Procedure Developed at the University of Utah

An initial decision was that all regular staff members would do intake interviews rather than employ specialized staff for this duty only, or designate practicum students as intake interviewers. All senior staff members and counseling interns (i.e., advanced doctoral students employed on a half-time basis with at least one year's prior supervised experience) were assigned to one-half day of intake duty per week. No regular appointments were made for them during this period. Intake counselors saw students initially on either a "walk-in" or an appointment basis. Students had the option of being seen as soon as they came to the Center, or, if they preferred, of making an appointment, usually within a day or two. Students who telephone were either invited to the Center immediately or given an appointment as soon as possible. Intake counselors were never scheduled for more than three or four intake appointments per half day. Since intake interviews were assumed to typically take around one-half hour this left time for two or three or, in an emergency, four "walk-in" intakes. In addition, to ease the burden on the intake counselor a norm was established among staff members to the effect that secretaries were free to request a counselor with an unscheduled hour to perform a "back-up" intake. To date this procedure has worked smoothly and we have seldom found ourselves swamped with walk-in clients.

All first-time clients, whether walk-in or appointment, complete a brief one page autobiographical inventory which is presented to the intake counselor at the onset of the interview. In addition, entrance test data, high school GPA and

university predicted GPA data is made available for all students who have scheduled an initial appointment.

Client and counselor jointly decide on the appropriate service that the Counseling Center will attempt to provide. This includes such options as, for example, ten minutes of information dispensing, referrral to a more appropriate campus agency, discussion of entrance test data and brief decision-making help, assignment to an individual counselor with expectations for either a short- or long-term contact, assignment to any of a variety of group experiences including efficient study groups, or some combination of the foregoing. The intake counselor is primarily responsible for the decision as to whom the client will be assigned. Options include a senior staff member, an intern, a group specialist, or a study skills specialist. When it seems appropriate, clients are occasionally assigned to an advanced (i.e., second or third quarter) practicum student. Such is not the case with first quarter practicum students, however; in all instances they work with volunteer clients who have previously been informed about the level of training of their counselor and the supervisory aspects of the relationship.

An option not yet mentioned is that the intake counselor, with the client's concurrence, may choose to assign the student to himself. This has seemed particularly appropriate in instances where intake counselor and client felt that a significant relationship has already begun to develop.

Some Questions

Following are the questions previously posed by Pappas along with our own subjective reactions to them:

1. Who will perform the intake role?

   Our answer has been that the more highly trained members of our staff should share in the performance of this role. Since an initial reason for implementing an intake procedure was to introduce an element of control in the assignment of clients to counselors, it seemed to make poor sense to assign minimally trained and experienced personnel to the intake function.

2. Does the intake role require special training?

   We have proceeded as if it does not; however, we may be in error. Our assumption has been that the well trained counselor possesses the sensitivity and informational resources necessary for the assessment and treatment decisions that are part of the intake experience.

3. Will counselor and client make the treatment assignment, or will some type of staffing be required?

   Practically speaking staffing of many cases would seem an impossibility. There is provision in our procedures, however, for staffing to occur and this has happened at infrequent intervals. If deemed appropriate psychiatric consultation through the campus Mental Health clinic can be a part of the staffing process.

4. Will the counseling relationship be limited in any way?

   As mentioned previously, the possibility exists for the intake interviewer to become the client's regular counselor. This has

served, we think, to minimize the intake counselor's concern over the development of a premature relationship and subsequent problems in referring to another staff member.

5. Should clients be required to complete autobiographical forms and test batteries prior to the intake contact?

In all cases clients complete a brief one-page autobiographical inventory. In no cases, however, are they required to complete tests prior to intake. When it seems clearly indicated, intake counselors are free to assign appropriate tests to be completed between the time of initial contact and appointment with a regular counselor. Thus far staff members have not objected to this procedure nor voiced concern over what they considered to be irrelevant and inappropriate testing.

6. How much involvement should the client have in the choice of treatment placement?

In our judgment clients who seek counseling services have every right to a full and clear explanation of services available and to participate jointly, using the special resources of the counselor, in the selection of services, or treatments, towards which they are motivated.

7. Should clients be advised of differential counselor experience and training before the initial treatment contact, or should that be described by the treatment counselor?

We wrestled with this problem for some time, with advocates for either point of view, and finally came to the conclusion that since some of our staff members were advanced graduate students, we were ethically obligated to inform clients before their involvement about the professional level of their counselor. If an assignment is made to a senior staff member the intake counselor will say something to the effect that "You will be working with Dr. _____ who is a counseling (or clinical) psychologist on our staff." In the case of an assignment to an intern the intake worker will say something like "You will be working with Mr. _____, an advanced graduate student in counseling (or clinical) psychology, who works as a half-time intern on our staff in consultation with Dr. _____, a senior staff member." (Each intern is assigned a regular staff member as supervisor.) The possibility then exists for the client to voice any concerns he might feel to the intake counselor; to date this has seldom occured.

8. Should clients be assigned to more than one treatment?

Upon occasion clients are assigned to more than one service as a result of the intake interview although more typically if multiple services are provided a client this decision is not made until after the primary treatment has been initiated.

SOME CONCLUSIONS

In summary, based on some seven months experience, the following disadvantages, or problems, seem a part of our new intake procedure:

1. Valuable staff time must be committed to the intake system, and this is not always easy in a Counseling Center upon which are placed heavy service and training demands.
2. Greater demands are placed on secretarial staff in such areas as scheduling, follow through on client data collection, and in seeing that "walk-in" clients are handled with dispatch and understanding.

All members of our staff, however, are sufficiently pleased with the new procedures to have little desire to the old system. Some specific benefits we see include the following:

1. Provision for immediate contact between a client requesting service and a professional level counselor.
2. The opportunity for professional judgment to be exercised in decisions regarding both service to be offered and level of staff member who will provide the service.
3. A more systematic and thorough procedure for collecting data to be used in appraising Counseling Center services and programs.
4. Stimulation to staff members for keeping abreast of Counseling Center programs and personnel, and university resources.

5. Provision for an efficient and quick procedure for dealing with clients requesting only information or brief decion-making help, or needing referral to another campus agency.

In a phrase, we like it...thus far.